Long-Term Care Hospital Prospective Payment System

What Is a Short-Stay Outlier?

A short-stay outlier is an adjustment to the Federal payment rate for Long-Term Care Hospital (LTCH) stays that are considerably shorter than the Average Length of Stay (ALOS) for a Long-Term Care-Diagnosis Related Group (LTC-DRG). Without this short-stay outlier adjustment, Medicare would be paying inappropriately for cases that did not receive a full episode of care at an LTCH. Cases qualify as a short-stay outlier when the Length of Stay (LOS) is between one day and up to, and including, 5/6 of the ALOS for the LTC-DRG to which the case is grouped. A length of stay that exceeds 5/6 of the ALOS for the LTC-DRG for the case is considered to have exceeded the short-stay outlier threshold. When a case exceeds the short-stay outlier threshold, Medicare pays a full LTC-DRG payment for that case.

Example:
If the ALOS for a particular LTC-DRG is 30 days, then the short-stay outlier policy applies to stays that are 25 days or less in length (i.e., 5/6 of 30 days = 25 days).

What Causes a Short-Stay Outlier Payment?

A short-stay outlier payment may occur in one of the following scenarios:

- An LTCH patient experiences an acute condition that requires urgent treatment or requires more intensive rehabilitation. The LTCH then discharges the patient to another facility.
- An LTCH patient does not require the level of care provided in an LTCH. The LTCH then discharges the patient to another facility.

Background

Long-Term Care Hospitals (LTCHs) treat patients with multi-comorbidities requiring long-stay hospital-level care. To be designated as aN LTCH, Medicare requires that a hospital typically demonstrates that on average, it has an average length of stay for its Medicare patients of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for LTCHs. The Long-Term Care Hospital Prospective Payment System (LTCH PPS) replaced the previous cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvements and Protection Act of 2000 (BIPA).

What Are Long-Term Care-Diagnosis Related Groups?

The LTCH PPS uses Long-Term Care-Diagnosis Related Groups (LTC-DRGs) as a patient classification system. Each patient stay is grouped into an LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status. Each LTC-DRG has a pre-determined Average Length of Stay (ALOS), or the typical Length of Stay (LOS) for a patient classified to the LTC-DRG. Under the LTCH PPS, an LTCH receives payment for each Medicare patient, based on the LTC-DRG to which that patient's stay is grouped. This grouping reflects the typical resources used for treating such a patient. Cases assigned to an LTC-DRG are paid according to the Federal payment rate, including adjustments. One type of case-level adjustment is a short-stay outlier.

Short-Stay Outliers Fact Sheet
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- An LTCH patient is discharged to his or her home.
- An LTCH patient expires within the first several days of admission to an LTCH.
- An LTCH patient's benefits exhaust during the LTCH stay (see the following example).

What If the Patient's Benefits Exhaust During the LTCH Stay?

Under the LTCH PPS, Medicare only pays for covered benefit days until the LOS triggers a full LTC-DRG payment. In other words, a patient's remaining amount of benefit days and the length of a hospital stay can affect LTCH payment, resulting in a short-stay outlier payment. For example:

If…	Then…	Example
A patient uses all of his or her regular benefit days for an episode during a length of stay that does not reach the short-stay outlier threshold for an LTC-DRG…	The patient is liable for any non-covered days. The provider receives a short-stay outlier payment for the patient's hospital stay.	The LTC-DRG short-stay outlier threshold is 25 days, and the patient's LOS is only 20 days, then the LTCH is paid the LTCH short-stay outlier payment. If the patient's benefit days end on Day 15, Medicare pays the facility for only the 15 covered days under the short-stay policy. Therefore, the patient is liable for Days 16-20 of the stay.
But. . .		
If…	*Then…*	*Example*
A patient uses all of his or her benefit days for an episode during an LOS that does exceed the short-stay outlier threshold for an LTC-DRG…	The patient is not liable for any non-covered days. Medicare pays the full LTC-DRG charges.	The LTC-DRG short-stay outlier threshold is 25 days, and the patient's benefit days end on Day 30. The patient's LOS is 35 days. The patient is not liable for Days 31-35. In this situation, the short-stay policy does not apply. Since the facility would receive the full LTC-DRG payment, the patient would not be liable until the first day the stay qualified as a "high cost" outlier (see the High Cost Outliers Fact Sheet).

Medicare provides 90 covered benefit days for an episode of care under the inpatient hospital benefit. In addition, each patient has 60 lifetime reserve days. These lifetime reserve days may be used to cover additional non-covered days of an episode of care that exceeds 90 days.

How Are Short-Stay Outliers Paid?

The payment for a short-stay outlier is the least of one of the following:

- The full payment for the LTC-DRG assigned to the case (see Calculation 1 in the following section).
- 120% of the LTC-DRG specific per diem. The per diem is calculated by dividing the full LTC-DRG payment by the ALOS for the LTC-DRG, and multiplying by the actual LOS of the case (see Calculation 2 in the following section).

Visit *www.cms.hhs.gov/LongTermCareHospitalPPS/01_Overview.asp* on the CMS website for more information.

- 100% of the cost of the case, calculated using the provider-specific Cost-to-Charge Ratio (CCR) (see Calculation 3 in the following section).
- A blend of the comparable Inpatient Prospective Payment System (IPPS) per diem amount and 120% of the LTCH PPS per diem amount (see Calculation 4 in the following section).

How Are Short-Stay Outlier Payments Calculated?

The following information is used to perform payment calculations to determine the basis of payment for a short-stay outlier in the following example of a Medicare patient in an LTCH in Chicago, IL [Core-Based Statistical Area (CBSA) 16974].

Data Used In Following Example Payment Calculations	
Length of Stay (LOS) for Case	10 days
Charges Incurred	$13,870.33
LTC-DRG for Case	LTC-DRG 113
Relative Weight for LTC-DRG 113(effective until 9/30/06)	1.4887
LTC ALOS for LTC-DRG (effective until 9/30/06)	39.3
5/6 of LTC ALOS for LTC-DRG (effective until 9/30/06)	32.8
Provider Cost-to-Charge Ratio (CCR)	0.8114
4/5 Wage Index for Provider Located in a CBSA Metropolitan Statistical Area (MSA)	1.0632

Calculation 1: Full LTC-DRG Payment Calculation	
((Standard Federal Rate x Labor Percentage) x (Wage Index Value)+ Non-Labor Share) x LTC-DRG Relative Weight	
$38,086.04	Standard Federal Rate for Rate Year 2007
x 0.75665	Labor-Related Share Percentage
$28,817.80	Labor Share
x 1.0632	Wage Index Value (FY06 = 4/5)
$30,639.09	Wage Adjusted Labor Share
+ 9,268.24	Non-Labor Share = $38,086.04 x 0.24335
$39,907.33	Adjusted Standard Federal Rate
x 1.4887	LTC-DRG 113 Relative Weight (for FY06)
$59,410.04	Full LTC-DRG Payment

Calculation 2: 120% of the Specific LTC-DRG Per-Diem Calculation	
Full LTC-DRG Payment x LOS of the Case / ALOS LTC-DRG	
$59,410.04	Full LTC-DRG Payment (See Calc. 1 Above)
39.3	ALOS for LTC-DRG 113
$1,511.71	Per Diem for LTC-DRG 113
x 10	LOS
$15,117.06	
x 1.2	Decimal Representation of 120%
$18,140.47	120% of Per Diem

Calculation 3: 100% of Cost Calculation	
Charges x CCR = Cost	
$13,870.33 x 0.8114 $11,254.39	Charges Incurred Provider CCR Cost
Calculation 4: Blend of IPPS and LTCH PPS Per Diems	
LTC-DRG Per Diem Portion of Blend Alternative *+ IPPS Per Diem Portion of the Blend Alternative* *Total Blend Alternative Payment*	
Step 1: Determine LTC–DRG Per Diem Portion of the Blend Alternative	
10 25 0.4 $18,140.47 x 0.4 $7,256.19	Case LOS Lesser of 5/6 of ALOS for LTC-DRG (32.8) or 25 Percentage of the 120% LTC-DRG Per Diem Amount for LOS 120% of Per-Diem (see Calc. 2) Percentage of the 120% LTC-DRG Per Diem Amount for LOS
Step 2: Determine IPPS Comparable Per Diem Portion of the Blend Alternative	
$,15,000 ÷ 10.8 $1,388.89 x 10 $13888.89 **$ 13,888.89** or $15,000 $13,888.89 x 0.6 $8,333.33	Full IPPS Comparable Amount IPPS ALOS Case LOS IPPS Comparable Per Diem Amount **Determine the Lesser of IPPS Comparable Per Diem Amount ($13,888.89)** or Full IPPS Comparable Amount ($15,000) 1-Percentage of the 120% LTC–DRG Per Diem Amount for LOS (1-0.4)IPPS comparable Per Diem Portion of the Blend Alternative
Step 3: Compute Total Payment Amount of the Blend Alternative	
$7,256.19 + $8,333.33 $15,589.52	LTC–DRG Per Diem Portion of the Blend Alternative IPPS Per Diem Portion of the Blend Alternative Total Payment Amount of the Blend Alternative

Resolution:

The example case is paid at 100% of cost ($11,254.39) since it is less than 120% of the specific LTC-DRG per diem ($18,140.47), less than the full LTC-DRG payment ($59,410.04), and less than the blend alternative amount ($15,589.52).

Who Determines If a Short-Stay Outlier Payment Applies?

The Fiscal Intermediary determines short-stay outliers using the PRICER software.

Visit *www.cms.hhs.gov/LongTermCareHospitalPPS/01_Overview.asp* on the CMS website for more information.

How Is the Cost-to-Charge Ratio (CCR) Determined in the Short-Stay Outlier Payment Calculation?

At the time of claim processing, Fiscal Intermediaries use an LTCH's CCR calculated from the latest settled or tentatively settled cost report (whichever is later). Additionally, the following CCR revisions may apply.

- CCR Revisions Requested by the Centers for Medicare & Medicaid Services (CMS): Fiscal Intermediaries may use an alternative CCR, as directed by CMS, which more accurately reflects recent substantial increases or decreases in a hospital's charges.
- CCR Revisions Requested by the LTCH: Upon approval by the respective Regional Office, LTCHs may request that Fiscal Intermediaries use a different (higher or lower) CCR. This request must be based on substantial evidence.
- CCR Determinations for LTCHs with CCRs Above the Maximum Threshold (Ceiling): Fiscal Intermediaries will assign the statewide average CCR to LTCHs with CCRs above the maximum threshold (ceiling), which is determined annually by CMS. For FY 2007, the LTCH "total" CCR ceiling is 1.321. Fiscal Intermediaries no longer assign the statewide average CCR to LTCHs with CCRs below the minimum threshold (floor). In those cases, Fiscal Intermediaries will use the LTCH's actual CCR.

In addition, the LTCH PPS outlier policy allows for reconciliation of short-stay outlier (and high cost outlier) payments upon cost report settlement. This reconciliation accounts for differences between the estimated CCR and the actual CCR for the period during which the discharge occurs.

How Is the Cost of the Case Determined in the Short-Stay Outlier Payment Calculation?

As shown in the previous examples, the cost of the case is determined by multiplying the Medicare covered charges for the stay by the hospital's overall CCR. For a short-stay outlier, the Medicare covered charges are the Medicare allowable charges incurred during the days of the stay in which the patient has a Medicare benefit day (either regular, coinsurance, and/or lifetime reserve) available, not the charges related to the length of stay for the episode of care (such as in the case where Medicare benefits are exhausted prior to exceeding the short-stay outlier threshold).

Final Rules That Affect the LTCH PPS

CMS published six Final Rules affecting Medicare payments to LTCHs on the following dates:

May 7, 2004 - the 2005 Rate Year (RY) Final Rule was published, increasing the Medicare payment rates for LTCHs, expanding the existing interrupted stay policy, finalizing the requirements for a satellite or remote location to qualify as an LTCH, and changing the ALOS calculation for LTCH status.

December 30, 2004 - the Fiscal Year (FY) 2005 IPPS Final Rule was published, containing a number of provisions contained in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

May 6, 2005 - the RY 2006 Final Rule was published, updating the annual payment rates effective July 1, 2005. In addition to revising the wage index, outlier fixed loss amount and the budget neutrality factor, the Final Rule also clarified the notification policy for co-located LTCHs and satellites of LTCHs and adopted new labor market area definitions based on Core-Based Statistical Areas (CBSAs).

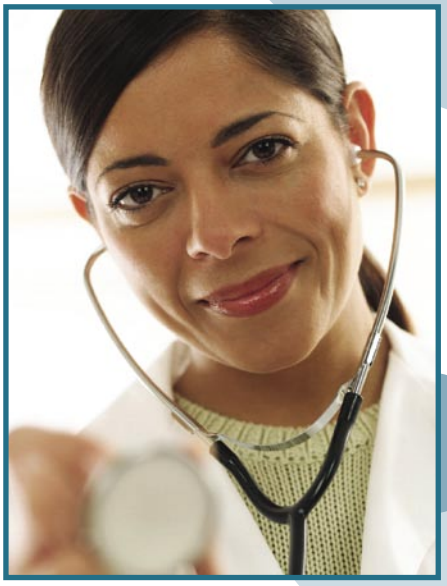
August 12, 2005 - The FY 2006 IPPS Final Rule was published, containing the LTC-DRGs, relative weights, and the ALOS for FY 2006.

May 12, 2006 - the RY 2007 Final Rule was published, updating the LTCH PPS payment rates, effective July 1, 2006. In addition, the Final Rule also revised the Short-Stay Outlier policy and removed the 3-day surgical exception to the Interrupted Stay policy.

August 18, 2006 - the FY 2007 IPPS Final Rule was published, which included revisions to the methodology for determining the LTCH PPS CCR ceiling and applicable statewide average CCRs, as well as clarification and codification of the existing policy regarding LTCHs' CCRs and the reconciliation of outlier payments.

How Will the Reconciliation of Short-Stay Outlier Payments Affect a Beneficiary's Lifetime Reserve Days and Eligibility for Coverage Under Medigap and Medicaid Programs?

Any changes to an LTCH's outlier payment made as a result of reconciliation will not retroactively affect a beneficiary's lifetime reserve days or coverage status under Medigap or Medicaid. Specifically, no retroactive adjustments will be made to determine the day that a beneficiary's stay moves to high cost outlier status. Therefore, no retroactive adjustments will be made to lifetime reserve days used or available. Similarly, no retroactive adjustments will be made to beneficiary benefits and payments under Medigap and Medicaid.



Can Short-Stay Outliers Also Be Eligible for High Cost Outlier Payments?

A short-stay outlier can also qualify for high cost outlier payments. The applicable short-stay outlier payment is used in determining the high cost outlier threshold (see the High Cost Outliers Fact Sheet).

Medicare Contracting Reform (MCR) Update

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FIs) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

Where Can I Find More Information about the LTCH PPS?

The following online references provide more information about the LTCH PPS:

- The Medicare Learning Network Web Page

  The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *www.cms.hhs.gov/MLNGenInfo* on the CMS website.
- Long-Term Care Prospective Payment System Web Page

  www.cms.hhs.gov/LongTermCareHospitalPPS/01_Overview.asp

  The Long-Term Care Hospital Web Page provides the Final Rules and additional LTCH PPS-related documents.
- LTCH PPS Press Release Updating the LTCH PPS for Rate Year 2007

  www.cms.hhs.gov/apps/media/press/release.asp?Counter=1848

  The press release summarizes how Medicare is updating the format and data of the LTCH PPS system for Rate Year 2007. These changes were also published in the Federal Register on May 12, 2006.
- LTCH PPS Final Rule on Annual Payment Rate Updates and Policy Changes

  www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/CMS1485F.pdf

  The LTCH PPS Final Rule provides a more in-depth look at the changes for Rate Year 2007.

Visit *www.cms.hhs.gov/LongTermCareHospitalPPS/01_Overview.asp* on the CMS website for more information.

- Federal Register Notice for Hospital Inpatient Prospective Payment System (IPPS) FY 2007 Final Rule (CMS-1488-F)

  www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/CMS1488F.pdf

  The FY 2007 IPPS Final Rule establishes changes to the methodology for determining the CCR ceiling and applicable statewide average CCRs used under the LTCH PPS, as well as clarification and codification of existing policy regarding the determination of LTCHs' CCRs and the reconciliation of LTCH PPS outlier payments. This Final Rule also contains the LTC-DRGs, relative weights, ALOS, and other IPPS-excluded hospital policy changes that are effective October 1, 2006, under the LTCH PPS.
- CMS Manual System - Medicare Claims Processing Manual - Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007 (Transmittal 981)

  www.cms.hhs.gov/transmittals/downloads/R981CP.pdf

  The CMS Manual System - Medicare Claims Processing Manual update provides updated payment rates, provisions, and updates to the Medicare Claims Processing Manual for the LTCH PPS Rate Year 2007.

Questions about short-stay outliers and the LTCH PPS can be emailed to *ltchpps@cms.hhs.gov*.

Where Can I Find More Information about ICD-9-CM Coding?

In previous LTCH PPS Final Rules, CMS emphasized that proper coding is essential for correct diagnosis and procedure reporting. The following online references provide ICD-9-CM coding guidance:

- The ICD-9-CM Official Guidelines for Coding and Reporting

  www.cdc.gov/nchs/data/icd9/icdguide.pdf

  The LTCH PPS Final Rule stated that the *ICD-9-CM Official Guidelines for Coding and Reporting* is essential reading for understanding how to report the proper diagnosis and procedure codes that are used in determining the LTC-DRG payment amounts.
- Updates to the ICD-9-CM Diagnosis and Procedure Codes

  www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/

  This website identifies the activities (including public meeting schedules and agendas) of the ICD-9-CM Coordination and Maintenance Committee charged with maintaining and updating the ICD-9-CM coding system.